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The Dilemma for American Business Regarding Health Care Reform

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THE DILEMMA FOR AMERICAN BUSINESS REGARDING HEALTH CARE REFORM

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DEDICATION

I started my M.B.A. at Lindenwood when I had two children and completed my degree when I had five. I dedicate this thesis, and degree, to all five children with full confidence that I will see each of them receive at least one college degree, if not more.

Terry

Caitlin

Colleen

Colin

Marin

Thesis

Businesses of all sizes will have to work together to adequately address controlling their health care costs. At the present time, large corporations have options available to them to control their health care costs, but these options will not be sufficient in the long-term. Since smaller businesses are increasingly declining to provide health insurance to their employees, the result is the growth of the working uninsured who will become a problem that cannot easily be contained and will affect the ability of large corporations to address their health care costs. The dilemma that American business faces is the need to develop strategies to work together to address the costs of health care, something that runs against the grain of individual companies that believe they can solve their own health care costs and do so in ways that will help them and will not adversely affect others.

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Chapter I:
Introduction: The Mutual and Inter-Related Problem of Health Care Costs for Businesses of All Sizes

With all the controversy and confusion that surrounded President Bill Clinton's failed health care reform policy, the impression created is that any discussion about health care reform is predominately a political issue. Business, however, has a stake in health care issues and, as this concluding project will explore, a graduate program in business administration cannot ignore a close examination of health costs and proposals to reform health care which will have an impact on American business. A 1984 study by the American Enterprise Institute for Public Policy Research stated:

> *Private sector initiatives to contain health care costs have become a striking feature of the changing health care marketplace in the past few years. Not long ago most private employers did little more than grumble as they paid ever-escalating premiums for their employees' health insurance.*(Sullivan 1)

This awakening involvement in health care reform for American business is understandable when one looks at employer spending. For example, between 1970 and 1989 (in constant 1989 dollars), while wages and salaries increased by 1 percent, and retirement benefits increased by 32 percent, health care costs went up by 163 percent. (Brown 340) Comparing the percentage increases for wages and salaries on one side with health care costs on the other side, raises an issue that one of the reasons why wages and salaries

have increased at such a miserable rate may be due in large part to the increases in health care costs.

Business, in looking at a total pool of money it spends on employees for salaries, retirement, and health care, apparently shifted employee dollars to health care. In 1948, for example health insurance accounted for less than 0.5 percent of total employee compensation, by 1990 it had risen to almost 6 percent of total compensation. (Goddeeris and Hogan 4) Therefore, bringing health care costs under control is not just important to the management side of the business ledger, it is of great importance to the worker side as well. As will be pointed out in some detail in this final project, health care costs never increased the same for all American businesses: small businesses experienced higher health care cost increases than large corporations. As a result, the costs of health care for smaller businesses to cover their employees became prohibitive and no amount of cost savings on the wage and salary side could prevent many of these businesses from dropping their health care programs. Ironically, while the 1980s is often seen as a period of long-term economic growth, an increasing number of workers were losing their employer-provided health insurance.

During the healthy economic growth era of the 1980s, more than six million people were added to the uninsured population in this country. One study concluded that, "nearly three-fourths of the most recent increase in the uninsured came from families with annual incomes of $25,000 or more."(Goddeeris and Hogan 4) Another way of understanding the growth rate of the uninsured during the 1980s, is to realize that while 9.5 percent of the

American population fell into the uninsured category in 1977, ten years later that figure had risen to 15.5 percent.

The seriousness of the situation meant that health care reform had to be addressed in the larger political arena and that became visibly apparent during the George Bush administration. Bush, reflecting a conservative approach to policy reform, advocated that proper health care reform should rest upon a voucher or tax credit plan. The way that the voucher plan was suppose to work was that workers could transfer vouchers to employers so they could participate in a company-based health insurance plan or they could use the voucher to obtain health insurance directly. Critics were not sure that those that worked and had no health coverage would see their lot in life improved by this plan. In addition, part of the problem with the Bush proposal was that it really never addressed the cost control issues associated with health care.(Mashaw 4-5) For a conservative, however, the Bush plan was seen as politically safe: it avoided any rationale for government interference in health care reform.

With the election of Bill Clinton in 1992, health care became a major political issue. Paul Starr, an advisor to the Clinton administration has pointed out that there was misunderstanding about the administration's proposal. Starr emphasized that there was concern within the administration that any government program that attempted to bring in workers would inevitably become very expensive. "If employers have a choice about entering a public program, the employers that stay out will be those with relatively low health costs, and the public program will have a

higher-risk, higher-cost enrollment."(Starr xix) Such a program would inevitably become a "fiscal albatross" attracting employers with an employee base defined as high-risk and low-wage. As a result of this concern, Clinton emphasized that any such government program would have to be "competit[ive] within a budget." (Starr xxi)

While aspects of an, essentially, capitated government universal health care program were being either distorted by Clinton critics or not being presented well by members of the administration, what was becoming apparent, although under-publicized, was that workers in this country fell into roughly two categories: those that had employers capable of providing health insurance and those without capability.

This distinction between businesses capable of providing health insurance to their employees and businesses incapable of providing health insurance is important to grasp. It is incorrect to make the assumption that business in general in this country has a common stake in how they look at health care reform related to health care costs. One might automatically assume that "businesspersons" are generally conservative and would favor less government intervention or regulation related to almost anything. While that particular political philosophy may be acceptable to a large corporation as it goes about the task of doing what it can to control its health care dollars, that might be a particularly bad approach for smaller businesses to adopt. Smaller businesses might need the assistance of government (whether at the national, state, or local level) to help them address their health care cost concerns. In other

words, there might be a conflict between how businesses look at health care reform in this country depending on their size.

This distinction between how different size businesses look at health care reform is not well developed within the business community. In looking at the criticism that mounted against Clinton's health care reform program, it was somewhat difficult to see clearly defined different positions being taken by interest groups representing different size businesses. The impression was that business, in general, was opposed to government sponsored or directed health care reform. Therefore, health care as a business issue should remain in the hands of businesses and in that setting it would be addressed and resolved. However, addressing the cost issue of health care is not a business issue that can be as easily addressed and resolved by small businesses in this country as is the case with large corporations.

As noted above, if the uninsured population trend is examined, the trend is for many of those recent arrivals to this terrible state of affairs to be among what is often described as the "working poor"(Levitan and Shapiro) As one study pointed out:

> *Not only are the bulk of the working poor excluded from medical coverage, but only a few receive health insurance from their jobs. Two-thirds of impoverished household heads who worked full time, forty weeks or more, in 1984 were not covered by employer or union-subsidized health insurance plans. ...The working poor who are fortunate enough to have group health coverage, as compared to higher paid workers, are likely to pay proportionately more of their wages for less adequate coverage.*(Levitan and Shapiro 104)

One of the ways of understanding this growth in the working poor as the uninsured is to note that in just one year between 1992 and 1993, the uninsured population increased by some two million going from 37 million to 39 million. In the case of Missouri where there are approximately 1 million uninsured, 75 percent of those uninsured are workers or dependents of workers.(Meyer) Nationally, a 1990 Congressional Budget Office report estimated that 80.2 percent of the uninsured were employed, 13.7 percent of the uninsured were not in workforce (generally meaning that many were dependents, therefore children), and only 6.1 percent were unemployed.(Congressional Budget Office xii)

It has been noted that beginning around 1992 the growth rate for health care costs began to slowdown, although it still grew it twice the rate of inflation. One of the reasons often cited for this slowdown in spending is because "medium" and "large" companies began to encourage their employees to participate in managed care health plans that limit the choice of doctors and the range of treatments. One *New York Times* article noted the size of the companies involved in health care reform. As the author of that particular article put it, "sixty-five percent of the workers in medium and large companies were in such plans by 1994."(Eckholm 1:1) Managed care sometimes carries an image of a break with traditional health insurance, where patients had developed a close relationship with their doctors over years, now under managed care they had to pick a doctor from a list they had no familiarity with. That image, whether real or not, regarding managed care plans, has led employers in some regions of the

country to create groups forcing health care providers to release information on medical results and patient satisfaction. Again, as the writer of the *Times* article points out, a certain size business is involved in this undertaking. "Larger employers, many working together in the Bay Area Business Group on Health in San Francisco, have already begun demanding that health plans produce data for public release...."(Eckholm 1:1)

In breaking the broader business community down into those businesses that have the capability to provide health insurance and those businesses that are currently incapable or will be incapable of providing health insurance if (and when) health costs begin to rise significantly again, the issue of who initiates reform aimed at reducing costs arises. On the one side, medium and, in particular, large corporations possess the capability to initiate efforts aimed at reducing their health care dollars. At least, that appears to be the case in the short-run. If, and when, health care costs begin to rise again, many of these efforts may be seen as attempts that temporarily did something but never seriously got a handle on the issue. Well, at least in the here and now, these larger businesses are being studied for their efforts on behalf of controlling health care costs, the case of smaller businesses is different.

For small businesses, any real attempt at reform aimed at controlling costs is meaningless and, therefore, government involvement, or the Rochester model (discussed in chapter three) that shows businesses of different sizes working together to control health care costs, might be instrumental in bringing about reform. Therefore, small businesses are not automatically dealing with

increased government regulation. It is, perhaps, the assumption that government involvement in medical reform is the only effective means to health care reform that prevents businesses from initiating reforms of their own.

Many small businesses realize that they are inadequate in dealing with the corporate restructuring that is taking place on the health care provider side of the equation. In contrast with small businesses, large corporations have some experience at controlling medical costs. Chrysler Corporation when it was in need of government financial assistance to stay afloat, realized that Blue Cross/Blue Shield was the corporation's largest supplier. To control medical costs, Chrysler moved to support health maintenance organizations, which Joseph Califano, former Secretary of Health, Education, and Welfare in the Jimmy Carter administration, noted was a type of health delivery provider "they once derided as socialistic."(Califano 4) By the end of 1984, as the company fully implemented cost containment measures, the results revealed that their health care budget was $58 million below budget. In other words, Chrysler showed some success at controlling medical costs.

As hospital mergers continue and increase in tempo, such as the Barnes, Jewish, and Christian hospitals' merger here in the St. Louis area, and as mergers and acquisitions occur among health insurance companies and pharmaceutical companies, a mismatch of gargantuan proportions will clearly develop: increasingly, small (and subsequently mid-size) business will be seen as lacking the clout to be heard. 1994 was significant for the health care industry,

since mergers of health providers surpassed in value that of any other industry for the first time.

With the restructuring underway within the health care provider industry, simple economic models that praise the marketplace as the true source of rationality and efficiency and serve as intellectual enrichment for those that want to reduce government's role in medical reform may be shortsighted. Charles Wolf, a noted economist has written that, "the choice in actuality is among imperfect markets, imperfect governments, and various combinations of the two."(Wolf 6) In applying this reasoning to how businesses address health care reform aimed at cost control, studying how medium and large businesses go about attempting to control health care dollars may not provide a broad rationale for government to stay at arm's length regarding all aspects of health care reform. The various proposals and solutions that seem applicable for medium and large companies may not provide a guide for small businesses which may need some kind of government involvement to help them address an issue they seem ill-suited to deal with.

One point to make regarding the notion of distinguishing businesses that have the capability to provide health insurance benefits to their employees and businesses that lack the capability is that there are legal developments underway which are serving to increase the idea that health insurance benefits are not automatically associated with employment in a large corporation. While the 1980s has shown that employees of small companies are in a precarious position regarding company-based health insurance

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One point to make regarding the notion of distinguishing businesses that have the capability to provide health insurance benefits to their employees and businesses that lack the capability is that there are legal developments underway which are serving to increase the idea that health insurance benefits are not automatically associated with employment in a large corporation. While the 1980s has shown that employees of small companies are in a precarious position regarding company-based health insurance

and their loss of those benefits has contributed significantly to the increased size of the uninsured population, court decisions--particularly by the United States Supreme Court--are increasingly putting a broadly diversified range of employees at risk of potentially seeing their health insurance benefits significantly altered. In a 1995 decision by the Supreme Court, the Court supported the Curtiss-Wright Corporation's decision back in 1983 to cancel benefits to retired nonunion employees at their Wood Ridge, New Jersey plant. The court based its decision on their interpretation of the Employee Retirement Income Security Act of 1974 (ERISA). Sandra Day O'Connor, writing the majority opinion for the court, concluded that ERISA does not automatically entitle employees to employer-provided health insurance, it only sets up procedures to be followed if a company decides to provide such benefits.(Asseo) The implications of ERISA and its legal interpretations are important to understand in terms of how business looks at health care reforms.

About a month after the Curtiss-Wright case, the Supreme Court handed down another opinion in a case involving the *Travelers Insurance Company*, which appeared to allow increased state government regulation over companies that set up health insurance programs under ERISA. Taking these two Supreme Court cases together, creates a great deal of confusion regarding business and health care reform. The *Travelers Insurance Company* case will be addressed in chapter four of this concluding project.

This concluding project for the Master of Business Administration degree, consists of five chapters. The introductory

chapter presented the problems that confront businesses of different sizes regarding their health care costs. As has been pointed out, it is important to examine businesses as falling into two broad categories, large corporations on the one side and small businesses on the other. In addition, as this introductory chapter has pointed out, there are contradictory approaches to health care reform depending on which category a business broadly fits. The second chapter will look at the literature available and note the lack of attention that addresses the thesis of this concluding project. The third chapter will examine health care reform and small business, looking at the impact of health care premiums and proposals designed to help these companies--particularly the idea of community rating. The fourth chapter will examine large business and how they approach health care reform. This chapter will examine managed care plans, ERISA, and self-insured health care plans. The fifth chapter will be a wrap-up chapter that addresses several issues, including the issue of cooperation. How do businesses of different sizes learn to work together on an issue of mutual importance? The concluding chapter addresses this question.

Endnotes

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Joseph Califano, Jr., America's Health Care Revolution (New York: Simon and Schuster inc., 1986).

Congress of the United States, Congressional Budget Office, Selected Options for Expanding Health Insurance Coverage (Washington: U.S. Government Printing Office, July 1991).

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Erik Eckholm. "Healing Process--A Special Report: While Congress remains silent, Health Care Transforms Itself," New York Times December 18, 1994.

Sar Levitan & Isaac Shapiro, Working but Poor: America's Contradiction (Baltimore: Johns Hopkins University Press, 1987).

Jerry Mashaw, "Taking Federalism Seriously: The Case for State-Led Health Care Reform," Domestic Affairs Number 2 (1993/94).

Ron Meyer, "Health Care Benefits For Missouri Local Governments," Missouri County Record Volume 1/Number 5 (July 1995).

Paul Starr, The Logic of Health Care Reform (New York, Whittle Books, 1992).

Sean Sullivan, Managing Health Care Costs: Private Sector Innovations (Washington: American Enterprise Institute, 1984).

Charles Wolf, Jr., Markets or Governments: Choosing between Imperfect Alternatives (Cambridge, Massachusetts, MIT Press, 1988).

Chapter II:
Literature Review

It is not easy to find publications that support the thesis of this concluding project, that businesses of all sizes will have to work together to address their mutual problem of health care costs for their employees and dependents. One study that examines the need for a "common civic purpose" is Larry Churchill, Self Interest and Universal Health Care: Why Well-insured Americans should support Coverage for Everyone (Cambridge, Mass.: Harvard University Press, 1994). Churchill is a philosopher so he does not address many of the specifics discussed in this concluding project. But, at least, Churchill presents the point of view that looking at yourself, or rather just your own company, is not the best way to approach health care reform.

There are a number of studies that address business aggressively pursuing health care cost controls. Sean Sullivan, Health Care Costs: Private Sector Innovations (Washington: American Enterprise Institute, 1984), examines different large companies and what they have done to address their health care costs. Also, Edmund Faltermeyer, "A Health Care Plan That Can Work," Fortune (June 14, 1993), praises business generally for introducing managed care and other private sector initiatives into health care and is critically of the Clinton administration's health care plan which subsequently failed to get through Congress. Joseph Califano, Jr., America's Health Care Revolution (New York: Simon & Schuster, Inc., 1984), explores the Chrysler Corporation's

success (at least up to the early 1980s) in controlling its health care costs; he also examines broader issues regarding health care. John Goodman and Gerald Musgrave, Patient Power: Solving America's Health Care Crisis (Washington: Cato Institute, 1992), presents a program which is now known as the Medical Savings Account as a means to reduce health care costs.

What is interesting about the studies cited above is that they are either outdated (Sullivan and Caliano fall into this category), or they see expectations of success in controlling health care costs in the future (Faltermeyer) or they propose untested and questionable solutions (Goodman and Musgrave). In other words, the studies cited above (representative of many that are available) are of limited use since they either fail to stand the "test of time" or are optimistic *if* what they want to see happen actually takes place.

In the third chapter of this concluding project, an alternative to the type of studies discussed above is present, the Rochester model. There are several studies that have examined developments in Rochester, New York including; James Block, "Competition and Regulation," Domestic Affairs, No.2 (Winter 1993/94),and Milt Freudenheim, "Rochester: An American Success Story," in Erik Eckholm, ed., Solving America's Health Care Crisis (New York: Times Book, 1993). The Rochester model began back in the 1920s and has shown a degree of success, if that success continues through the end of the 1990s, more studies may begin to take notice of this model.

Studies that look at broader methods of controlling health care costs, usually focus on the topic of community rating (discussed in

chapter three), or focus on the role of state government in helping small business(where the working uninsured are concentrated). For example, John Goddeeris and Andrew Hogan, eds., Improving Access to Health Care: What Can the States Do? (Kalamazoo: Mich., W.E. Upjohn Institute for Employment Research, 1992), Howard Leichter, ed., Health Policy Reform in America: Innovations from the States (Armonk, N.Y.: M.E. Sharp, Inc., 1992), and Mark Holoweiko, "Health-care reform: What does Hawaii have to teach?" Medical Economics (February 3, 1992), look at states and what they currently doing or planning to undertake. In addition, John DiIulio, Jr. and Richard Nathan, eds., Making Health Reform Work: The View from the States (Washington: Brookings Institution, 1994) examines states from the point of view of categories used to approach health care reform, rather than the state case study method in the studies cited above.

There are studies that address broad national issues of health care reform, inevitably raising the issue of the role of the federal government. Paul Starr, The Logic of Health Care Reform: Why and How the President's Plan Will Work (New York: Penguin Books, 1994, revised) discusses the Clinton administration health care plan (Starr was an advisor to the administration on health care) and then proceeds to address reasons why business should support the plan. Rashi Fein, Medical Care, Medical Costs: The Search for a Health Insurance Policy (Cambridge, Mass.: Harvard University Press, 1989, revised) discusses the need for a universal health care plan otherwise he believes the situation will get worse. Henry Aaron, Serious and Unstable Condition: Financing

America's Health Care (Washington: Brookings Institution, 1991), examines reasons why health care costs go up, focusing particular attention on medical technology as not fitting the usual economic pattern of bringing costs down but, in this case, acting as a driving force behind medical cost increases.

From a different perspective, there are several studies that look at hospitals. Walt Bogdanich, The Great White Lie: Dishonesty, Waste, and Incompetence in the Medical Community (New York: Simon & Schuster, 1991), examines hospital pricing practices, obviously from the title this is not a favorable treatment of hospitals. Rosemary Stevens, In Sickness and In Wealth: American Hospitals in the Twentieth Century (New York: Basic Books, 1989), provides an historical perspective leading to current issues in health care reform affecting hospitals.

A good introduction to the issue of insurance regulation as an industry is provided in Betty Leyerle, The Private Regulation of American Health Care (Armonk, N.Y.: M.E. Sharpe, Inc., 1994). Leyerle is critical of business regulation and believes that government involvement is needed to, at least, provide a degree of patient participation in health care. Leyerle sees a system of business regulation that has emerged since the 1970s that has created division and polarization, preventing concerted political action from taking place.

As can be seen, studies that look at the need for collective action by businesses of all sizes are difficult to find. Generally, some of the studies discussed in this chapter examine the benefits of community rating as opposed to experience rating, this serves as

a basis to explore the need for collective business action to address the problems of health care costs.

One study that address the question "When should cooperation take place?" is a theoretical study that is based on mathematical game theories, Robert Axelrod, The Evolution of Cooperation (New York: Basic Books, 1984). Axelrod's question will be addressed in chapter five, the conclusion.

Chapter III
Health Care Reform and Small Business: The Inability to do Much for Itself

In a statement responding to the proposed Clinton administration's Health Security Act which failed to make its way out of Congress, the National Federation of Independent Business (NFIB), an organization representing more than 600,000 businesses ranging from small high-tech firms to neighborhood retailers, the point was raised that health insurance premiums had increased at a rate of 79 percent over four years. As the NFIB statement emphasized, "smaller firms actually experience premium increases 50% higher than big businesses, and pay more than twice as much in administrative costs."(National Federation of Independent Business) Furthermore, the NFIB pointed out the precarious situation many small firms find themselves caught in regarding health premiums noting that, "premiums are highly volatile and policies are often suddenly canceled."

The NFIB supported the creation of "health alliances" (part of Clinton's Health Security Act proposal which was subsequently dropped). The purpose of these alliances was to serve as large health insurance brokers that would either control or reduce the cost of insurance through their size by increasing their buying power. While this sounds like a business group supporting the Clinton health plan, the NFIB emphasized that they were opposed to employer mandates that required small businesses to join these alliances or any government law that made it obligatory for them to

provide health insurance to their employees. The NFIB's statement concluded:

> *Most small firms fear a broad government mandate requiring employers to purchase health insurance for all employees. Most small firms fear a broad government mandate for two reasons: the business owner would lose the flexibility to package fringe benefits that are best suited to their employees, and an expensive government-dictated benefits package could mean that their already high costs would escalate further.*(National Federation of Independent Business)

In examining the composition of the "working uninsured," a 1987 study by the Upjohn Institute for Employment Research, noted that 33.7 percent of the uninsured worked in firms with less than 10 employees, that 13.3 percent worked in firms with 10-25 employees, but only 5.3 percent worked in firms with over 100 employees. In addition, 46.2 percent of all uninsured were full-time workers.(Bashshur and Webb 29) Furthermore, the same study noted that (for 1987), 19.7 percent of the uninsured made between $3.51-$5.00 an hour, 24.4 percent made between $5.01-$10.00 an hour, but only 3.7 percent made over $15.00 an hour. In referring back to the statement made by the National Federation of Independent Business, the fact that the uninsured workers are concentrated in very small businesses and make low wages, raises serious concerns that without government mandates these businesses would be inclined to voluntarily join alliances that would purchase health insurance for their employees. Another way of doubting that small businesses would voluntarily join alliances if they were created to help them purchase health insurance for

their employees, is to realize that 41.3 percent of the uninsured are concentrated in the South, a region not traditionally inclined to support fringe benefits for workers, while only 15.9 percent of the uninsured are in the Northeast, a region where unions have been stronger and where support for fringe benefits developed early.

The Clinton health plan as it was revised after being presented to Congress, aimed at providing government subsidies to businesses with 75 or fewer employees (originally the plan called for government subsidies to companies with 50 or fewer employees). Despite attempts to "sweeten the pie," there were strong doubts that many small businesses with low wage workers would voluntarily provide health care coverage.(Wall Street Journal B2)

As pointed out in the first chapter, small businesspersons are inclined to be conservative, much like businesspersons in larger businesses: a general attitude of reducing government regulations across-the board appeals to a conservative mind-set. Yet, for how long will small businesses be able to continue the luxury of this type thinking, regarding the issue of health insurance?

There is every indication that health costs, and therefore health premiums, will continue to rise at rates seen as unacceptable. As the baby boomers age, long-term health care will increasingly become a predominate health care issue.(Gokhale and Leovic) In looking at projected trends regarding the employment pool, the Bureau of Labor Statistics, expects the median age of the labor force to increase by the year 2000. In the post-Second World War years, the median age peaked at 40.6 years in 1962, and then

declined as the baby boom generation entered the workforce in the 1970s. For example, the median age of the labor force was down to 34.6 years by 1980, but then it began to increase, reaching 35.3 years by 1986 and is projected to increase to 38.9 years by 2000.(Bureau of Labor Statistics 24) Health insurance is predominately based on an experience rated system, which breaks the insured down into categories such as age and sex. Health premiums for men tend to be lower than for women (related to fears associated with complications arising from child bearing). In addition, younger workers have lower premiums than older workers (related to increased risks of health problems as people age).

In looking at small businesses, the healthy economic growth era of the 1980s, is often credited to the growth rate of small businesses. Between 1980 and 1982, almost all of the some 984,000 new jobs created in the economy were generated by firms with less than 20 employees. In 1983, small business employment grew at a rate faster than larger business employment. Based on this information it is understandable why in the midst of the long-term economic growth of the 1980s, the uninsured population increased noticeably: employment occurred in those businesses least likely to provide health insurance as a fringe benefit. Assuming that the Republican-controlled Congress demonstrates the capability to reduce government regulations, as a way of aiding the growth of small businesses, this country may see the growth of more small businesses as the driving force for new job creation .

For example, as one study concluded regarding the 1980s and the growth of small businesses:

> *While it may be difficult to ascertain the effect of deregulation on the economy or employment statistics, certainly the creation of small business in sectors which require little or no capital investment dollars would lend itself to increased statistical change. From what is evident this far, deregulation is causing a major shift toward more independence and self-employment in some selected industries such as warehousing, distribution and/or trucking.*(Gudasky I-8)

According to the 1987 Upjohn study noted earlier, the self-employed constituted 14.7 percent of the uninsured population. While the image of the entrepreneurial spirit taking hold in self-employed and small businesses is seen as reflecting "American know-how" and is wrapped in patriotism, the dark side of this economic trend is a country with more uninsured.

It is understandable why *Fortune* in assessing the proposed Clinton health care plan wanted a mandate that **made** employers provide health insurance for their workers. The *Fortune* proposal did add that "the government must subsidize companies that pay low wages."(Faltermayer 55) However, *Fortune* seemed to be clearly at odds with the position on employer mandates taken by the National Federation of Independent Business: *Fortune* no doubt reflected the views of big business. (The Clinton plan did include a mandate forcing employers to provide health insurance, however, there were caps on the percentage of payroll expenses that employers would be required to put out. After a certain

percentage cap, the government would provide subsidies to help different categories of small businesses, depending on employee size and salary averages.)

A large part of the reason why *Fortune*, as reflective of the views of big business, would be supportive of a position that increases government involvement in health care reform, has to do with issues associated with the health status of the uninsured. A woman who does not regularly see an OB/GYN is likely to give birth to a premature, low-weight baby that will add between $14,000-$30,000 in infant health care costs during the first year of life. In the case of Missouri, the proportion of babies born weighing less than 5.5 pounds (so low weight) has increased since 1988.(Shirk) Considering that these women tend to be uninsured, usually coming into a hospital emergency room as their water breaks, raises the issue that if they had access to an OB/GYN much unnecessary cost could be avoided. Considering that some 47.9 percent of the uninsured are women and that the vast majority of those women are of child-bearing age, does not provide for the prospects of controlling unnecessary health costs.

Women as a percentage of the total workforce in this country will increase slightly through the year 2000. Considering that many women will work for less wages than men and more likely work for smaller firms, the prospects of uninsured, child-bearing age women increasing is likely. One study that commented on the impact of the economic growth of the 1980s on working women stated that, "the proportion of women working under the poverty

line rose from 35.2 percent to 39.5 percent."(Harrison and Gorham 243)

Interestingly, attempts to bring pregnant women into the Medicaid program who were not previously enrolled as a means of providing prenatal care and, therefore, reducing the costs associated with birth complications, has not been all that successful. HealthPASS was a plan set up in the west Philadelphia area to address the problems of pregnant women not receiving prenatal care. However, HealthPASS was unable to schedule first prenatal visits until toward the end of the fifth month of pregnancy--well beyond the point when first visits should have occurred. In the case of HealthPASS, 20 percent of the newborns of women in the program were low weight babies and required expensive care.(Melden) This particular program's failure raises an interesting issue associated with attempts to provide universal coverage, as the Clinton plan had envisioned--universal coverage may not necessarily work all that smoothly.

Another demographic figure that is disturbing is that much of the growth rate in the labor force through the year 2000 is projected to consist of minorities--particularly black Americans. The Bureau of Labor Statistics concluded that while "the white labor force is projected to increase less than 15 percent, ...the black labor force is expected to grow by nearly 29 percent, or 3.7 million workers, more than 17 percent of the projected total labor force increase."(Bureau of Labor Statistics 1) Among many black Americans, health care has reached crisis proportions. For

example, one study described the health of black men in inner city communities:

> *...The men of this inner-city community were less likely to reach their sixty-fifth birthday than men in Bangladesh-an impoverished Third World country. [It has been] urged that, given the extraordinarily high death rates of Harlem-and other urban minority communities-the nation treat these neighborhoods with the same consideration given to natural disaster areas.*(McBride 319)

Given the experience-rating health insurance system that predominates this country's health insurance coverage, again where differences in age and sex effect health premiums, it can be assumed that race can be a factor as well and that assumptions about a black population seen of as more likely to be unhealthy than a white population will only mean higher health premiums that more businesses--particularly small businesses--will be unable to afford.

The Bureau of Labor Statistics report, noted several places earlier in this chapter, summarized the composition of the workforce in the year 2000 as "increasingly minority and female."(Bureau of Labor Statistics 1) While there may be reason to express optimism regarding an increased diversity of the workforce, how this workforce will fare in terms of health insurance premiums does not look good. Furthermore, a common assumption of many economists and politicians is that if the American economy experiences a lengthy period of good economic growth that good jobs with above adequate pay will follow,

however, that type of thinking is not necessarily correct. A troubling aspect of the economic growth of the 1980s is that income inequality increased. Generally, two-wage earner families did somewhat well during the 1980s economic growth period, but many other did not fare so well. For example, one study noted that, "significant real income losses [occurred] among the poorest households headed by blacks, Hispanics, females, and young persons...."(Michel 200)

In looking at the uninsured population in a broader sense than their demographic composition, a Office of Technology Assessment (OTA) report noted that the uninsured are significantly discriminated against regarding their health care treatment. This report raised the question "Does health insurance matter?" and concluded, "uninsured Americans may be up to 3 times more likely than privately insured individuals to experience a lower health care utilization rate, potentially inadequate health care, and adverse health outcomes."(Office of Technology Assessment 2)

It is no wonder why critics of the Clinton Health Security Act raised concerns about the costs that would fall upon the federal government--despite efforts by the administration to emphasize the capitated aspects of their proposed program. In looking at the underlying purpose of the Clinton plan, namely to provide health insurance to the uninsured, it is understandable why one health care consultant wrote, "[the now uninsured as] new insurees have historically needed more and received less health care than the insured. Hospitals and physicians will be under pressure to provide a greater volume of benefits."(Weil 27) Obviously,

increased health care of a higher quality than has been given in the past to the uninsured will be expensive and someone will have to pay. If it is assumed that among the uninsured are members of the cohort known as the baby boom generation, and they are aging along with their insured compatriots, then problems of health care for the uninsured will only get worse. Under these conditions, the gap between health care premiums offered to small firms with low-wage and generally more unhealthy workers and large corporations with insured plan and generally healthier employees, will only lead to a widening in the gap between health premiums available to small firms and premiums offered to large firms.

In getting back to the *Fortune* article noted earlier in this chapter, where *Fortune* supported a position of mandates on employers offering health insurance, the concern that big business has is that there will continue to be an increase in uncompensated care by both hospitals and physicians and that, regardless of managed care plans that attempt to keep health costs under control, someone will have to pay.

Ironically, a Republican-controlled Congress that supports a balanced budget amendment, and despite efforts to achieve one, is willing to make cuts to significantly reduce the deficit, will have to direct its attention significantly at controlling costs associated with Medicare and Medicaid. One Missouri hospital administrator noted that Medicare accounts for up to 40 percent of all hospital revenues; in the case of his hospital, Medicare has accounted for 55 percent of their revenues. In a letter to Representative Richard Gephardt (D.,MO), regarding his criticisms and concerns about

Clinton's health care plan, the administrator raised the issue of cost shifting:

> *If the Medicare and Medicaid programs would simply pay their share of the costs, this Hospital and 99 percent of the hospitals across the country could reduce their charges by approximately one-third and maintain the same bottomline, thereby supporting qualified staff, new technology, and uninterrupted community service. But no one wants to talk about this! Why? The cost shift that has become a legitimate burden to American businesses is a result of Medicare not paying for its own program benefits.(*Wente)

While the Clinton health plan may be history, the underlying reasons associated with cost shifting have not disappeared. In the case of the letter noted above, the onus for controlling health care costs is placed on Medicare, however, that does not address the broader issue of a growing uninsured population that is in all likelihood getting more unhealthy. Medicare deals with the elderly; the pregnant, uninsured woman making it to the door of a hospital emergency room and then contributing to, in some cases, the hospital's uncompensated health care costs is not addressed. Some of the funds that hospitals receive for uncompensated care come from Medicaid programs. Within state Medicaid programs there is a fund to support hospitals and the uncompensated care they give: this program is called the Disproportionate Share Fund (DSF). One study noted the impact of the DSF on state Medicaid cost increases. As that study stated, "one of the major factors causing the rapid growth of Medicaid expenditures from 1989 to 1992 was the increasing State use of DS[F]."(Ku and Coughlin 27)

Controlling much of the cost increase of Medicaid means bringing the DSF under control. With Medicaid seen as consuming large amounts of state funds, attempts to control these costs could come from state limits on uncompensated care, in that case hospitals would be placed in the unenviable position of absorbing uncompensated costs or attempting to "pass them along"--a particularly difficult thing to do if a hospital deals with increased patients covered under managed care programs. Obviously, big business is concerned that the health costs for employees enrolled in traditional indemnity plans that allows patients the freedom to choose their doctors and hospitals, would be a source for price shifting, inevitably driving premiums higher than they should be (which is probably the case already).

The issue of cost shifting is real and of concern to more than just big business--it is of concern to labor unions as well. The New Jersey state government, for example, adds a 19.4 percent surcharge on the bills of insured patients in order to cover uncompensated hospital costs. Labor leaders oppose this plan on the grounds that it discriminates against those with insurance. Obviously, if hospital costs go up for union members, the issue of the growth rate of health premium costs to salary increases raised in the first chapter becomes a real issue.

With state governments experiencing slow growth in revenues to support public programs, one of those being Medicaid (and the DSF within it), funding sources have to be found somewhere to alleviate the problem of public treasuries dealing with the

uninsured: New Jersey has found one solution to the problem.(Ignagni 40-41)

The New Jersey funding plan was similar to a plan in New York which was subsequently challenged in federal court and worked its way up to the United States Supreme Court. In a decision handed down in April 1995 (in a case simply known as the *Travelers Insurance Company* case), the Court upheld the New York state provisions for surcharges collected by hospitals from patients covered by commercial insurers but not from patients covered by a Blue Cross/Blue Shield plan.

The *Travelers Insurance Company* case is significant since it allows New York to continue collecting funds from insured patients covered by self-insured plans as a way to cover the costs of hospitals providing care to the uninsured. In essence, cost shifting is now supported, somewhat indirectly, by the Supreme Court. In the *Travelers Insurance Company* case, Justice David Souter, writing the Opinion of the Court, noted that "the Blues" were different than commercial insurance companies:

> *...the Blues pay the hospitals promptly and efficiently and, more important, provide coverage for many subscribers whom the commercial insurers would reject as unacceptable risks. The Blues' practice called open enrollment, was consistently being cited as the principle reason for charge differentials.*(New York Conference et. al. 21)

Justice Souter raised the issue of a surcharge on insured patients and its possible impact on the costs to their insurance plans. He

referred to a possible increase in these insurance costs as "an indirect economic influence" and wrote:

> *An indirect economic influence, however, does not bind [health] plan administrators to any particular choice...commercial insurers and [health maintenance organizations] may still offer more attractive packages than Blues.*(New York Conference et. al. 21)

The impact of this case on self-insured plans in both New York and New Jersey, however, may lead to a realization by large companies that they need to look closely at their relationship to small companies (with a disproportionate share of uninsured workers): business attempts to control health care costs may begin to be seen as more than confined to what one company does by itself or one group of companies does together.

As emphasized in the first chapter, small business cannot seriously look at health care reform leading to controlling costs on their own, it is difficult to find examples where small businesses have managed to do much successfully on their own. However, there is an example of businesses working together at controlling costs--without government involvement: the Rochester model.

Rochester, New York is often cited as an example of a health cost control success story. Here is a city with approximately 232,000 residents of which only 6 percent are uninsured, well below the national average of 15 percent. The Rochester model is an example of big business having developed the insight to realize that it needed to formulate health reform efforts in conjunction with the larger community in which they exist--not solely focusing

on their own employees. A *New York Times* article described the inter-relationship between big and small business on health care:

> *The Rochester program has served the interests of the city's largest employers, including Eastman Kodak and Xerox, by holding down the growth in costly health-care benefits. But the chief beneficiaries have been the families and small businesses that typically would not have access to affordable care because they were not part of a larger group. Under the Rochester plan they pay the same monthly premiums for each person as Kodak and Xerox, for equal benefits. And unlike most health-care plans for small groups, no one pays more or is refused coverage because of age, sex, or previous medical condition.*(Freudenheim 206-207)

Several reasons are cited for Rochester's success in keeping the number of area uninsured low and in keeping health premiums down (in 1991, Kodak's health premiums at its Rochester operations averaged 25 percent lower than at the company's locations elsewhere around the United States). The first reason often cited for Rochester's success is that the major corporations in the area did not opt to self-insure, which they could have done under ERISA. (Self-insured health insurance will be discussed in the next chapter.) The point to make here is that as a result of not self-insuring then almost all area businesses buy from Rochester Area Blue Cross. If the large corporations in Rochester had followed the national pattern of self-insuring, then an entire patchwork of separate insurance plans would exist, which would allow companies to be more at the mercy of insurance companies.

As it is, a united business front serves to act as one large purchasing group with bargaining power.

In addition to corporations agreeing to not self-insure, business has been active in the Rochester area, dating back to the 1920s in working to keep medical costs under control. For example, in the 1950s Kodak was instrumental in creating the Patient Care Planning Council, an organization which includes consumers, hospital administrators, physicians, and representatives from local business and government.(Cernik) This second point is important to bear in mind, since it indicates a long traditional of business working at controlling medical costs: this history of involvement and success before health care costs started to become a visible business expense issue in the 1970s, is an important reason to understand why the Rochester model may not be easily transferred to other cities in the United States.

The third reason cited for keeping medical costs under control and keeping the uninsured population low in Rochester is because of the use of community rating for health premiums. Community rating was the original way that Blue Cross established health premiums. Under a community rated system, everyone was included in a large health insurance pool, both the healthy and the not-so-healthy. In essence, premiums--which could have been offered at lower rates for the younger and more healthy in the pool--were slightly higher in order to keep the premiums for the older and more likely to be unhealthy from becoming not affordable. This notion of community rating, by the way, does not just apply to health care. For years, AT&T has had a high/low pricing scheme,

whereby, say, telephone users in a highly congested area might be paying slighter higher rates than they should to help subsidize service to areas in the country which are more rural and phone usage is a great deal more sparse.

Community rating began to become challenged by insurance companies that wanted to attract potential customers away from Blue Cross: this led to the rise of experience rating or "cherry picking." Under experience rating, variables are worked into an insurance companies calculations to address age, sex, and occupation (imagine the difficulty a male hair dresser has getting insurance coverage, considering the fear of AIDS and the assumption among many in the general public that this is an occupation inclined to attract gay men). The difference in premiums offered to certain age, sex, and occupation categories can be significant in looking at community versus experience ratings. For example, a man between the ages of 18-29, therefore young and healthy and unlikely to need medical care, might have an experience rated premium of $98.50, which is $48.94 lower than would be the case in a community rating system.(Cernik) A woman between the ages of 18-29, however, would have an experience rated premium of $184.00 which is $36.56 higher than a community rated premium. The difference, obviously, is that a woman between 18-29 is seen as in the prime child-bearing years--and that means the fear of birth complications. The higher up in age, the more the experience rated premium is above the community rated premium.(Cernik)

The point to bear in mind about experience rating is that it has a built-in bias against small groups. As put by one writer, "All things being equal, covering 10,000 persons is always cheaper than covering 500 people. Most people are healthy. The insurer is able to spread the risk."(Castro) Therefore, the Rochester model's capability to keep the percentage of the uninsured low is very much related to the use of community rating--something that only works in conjunction with the city's large corporations agreeing to not self-insure.

The Rochester model consists of three basic elements; control the growth of self-insured companies, community rating, and a history of business actively working to control medical costs: two of those elements can be transferred to other parts of the country. The point to, again, emphasize is that the two elements that can be transferred to other parts of the country need to be used together: community rating only works if a number of medium and large size firms agree to not self-insure. In other words, while this final project has been distinguishing between businesses of different sizes, there is a clear inter-relationship that needs to be developed and strengthened if business in general expects to get a handle on controlling medical costs. Earlier in this chapter, a *Fortune* article was discussed where the position taken was that the government needed to mandate employers to provide health insurance to their employees. That particular article was interesting in that it never raised the issue of self-insured status. While the author of that piece discussed the notion of "health alliances" to creates buying pools that would allow small businesses to get lower health

premiums, the buying strength of these pools would be dependent on the number of employers that were kept out of an alliance because their employers were self-insured.(Faltermayer)

Some large businesses are beginning to "see the light of day" and realize that substantive attempts at controlling their health care costs have to include a working relationship with smaller businesses. The Colorado Health Care Purchasing Alliance is a group purchasing arrangement that included large self-insured companies. As the vice president for marketing of the Alliance stated:

> *Now we recognize the need to respond to a broader segment of the market. We know we need to work with all employers in order to effect systemic changes in the health care market.*(Woolsey 21)

The Alliance will begin to allow small fully insured firms to join. The business environment in Colorado supports development of a working relationship between large and small businesses since 93.8 percent of the state's businesses have 50 or fewer employees. Interestingly, the base premium will be different depending on whether the business is small (2-50 employees), medium (51-200 employees), or large (over 200 employees).

It may be ironic that the unwillingness of many large corporations to appreciate the significance of the Rochester model is providing the rationale for more government involvement in health care. In essence, an unwillingness of business in general to

see a symbiotic relationship between large and small firms regarding health care reform, does them little good.

One point to note about the Rochester model is that it is not an example of market forces are work: Blue Cross/Blue Shield dominates the market with some 75 percent of the business. In essence, this is not an example of perfect market competition. Market efficiency, is based on a belief that a large number of sellers competing for the business of buyers serves to bring about price control. However, in the case of the Rochester model, an imperfect market has been established. Market competition would lead to an increase in experience rated insurance companies competing, therefore contributing to a rise in the number of uninsured since small companies would be forced out of the health care insurance marketplace.(Congressional Budget Office)

During the 1980s, attempts to establish market competition in health care delivery services as a means of controlling medical cost increases, were tried in earnest. In California and the Minneapolis/St. Paul areas, there were signs of a slower growth rate in medical costs due to competition in health care delivery. Yet, disillusionment set in and market competition has not been seen as the cure for medical cost increases. One study commenting on the problems of competition noted that:

> *If market competition has rewarded efficient and punished inefficient hospitals one would expect to see overbuilt hospitals in competitive urban markets experiencing financial trouble or going out of business. Hospital closures have increased in recent years, but most of the failed facilities have been either rural hospitals or urban hospitals serving a disproportionate share of indigent patients.*(Higgins 66)

In sum, it is important to realize how little small business can do for itself regarding health care costs. The current practice of small business employers simply providing no insurance to employees and their families, and in essence telling them to receive treatment through taxpayer dollars, while they preach a gospel of conservatism, encourages government to step in and do something. The Rochester model is interesting in that it provides some form of relief, however, it is debatable how many businesses of any size will take its lesson to heart.

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Chapter IV
Health Care Reform and Big Business: The False Belief that it can do Much to Help Itself

In August 1994, it was announced that fifteen of the largest companies in the St. Louis area had joined together to create a health-care purchasing association as a way of increasing their purchasing power in order to bring the cost of health care down. This new association would negotiate with area hospitals, doctors, and health insurance companies. Among the companies involved are the McDonnell Douglas Corporation, the area's largest employer, Ralston Purina Company, Union Electric Company, and Monsanto Company.(Goodman) Representing a combined employment pool of some 140,000 with $210 million spent in 1993 on health care, this association felt that its collective voice would be heard and felt.

What is interesting about this new conglomerate being created as a means to control medical costs for big business is that it says something about past measures that business has tried in order to control costs: previous cost control measures may not have worked all that well. For example, during the 1980s, employers pushed the idea that managed care programs were the answer to controlling medical costs. In 1980, only 5 percent of all private employees were enrolled in managed care plans, while by 1992, 55 percent were enrolled. Managed care as a term is very broad since it runs the gamut from Health Maintenance Organizations (HMO), which are seen as the most restrictive type of managed care program requiring enrollees to use only specifically approved doctors and

hospitals, to Point-of-Service organizations (POS), which allow a degree of flexibility in providing service within limited choices, to Preferred Provider Organizations (PPO), which encourage patients to use physicians or hospitals from an approved list, but allow them the option to go outside the list (or network) to use their own doctor or hospital (similar to an indemnity plan) as long as they are willing to put more of their own money into their health care. Of employees enrolled in managed care programs, approximately 68 percent are in HMOs, 7 percent are in POSs, and 25 percent are in PPOs.

As the last chapter concluded, it has been noted that marketplace competition has not been a big success in controlling health care costs. The proliferation of managed care plans was suppose to help create competition and thereby bring costs down, but as a General Accounting Office report has discovered there are problems in adequately measuring cost savings:

> *Employers have implemented managed care plans with optimistic financial expectations. [However],...most studies comparing firms' health care costs for employees under managed care and indemnity plans do not adequately control for key factors affecting cost, such as employees' age or health status. Consequently, because of the tendency of managed care plans to attract younger and healthier employees, cost savings revealed in many studies may be attributable to employee health status rather than to cost containment.*(General Accounting Office 1,3)

One of the problems associated with managed care programs includes the realization that while there is a one-time reduction in

medical costs, after enrollment, managed care plans have tended to increase at rates similar to indemnity plans, therefore costs continue to climb at unacceptable rates. Of the three types of managed care programs discussed above, HMOs are seen as averaging premiums that are 11 percent below PPOs, due mainly to reducing hospital stays (but not the number of hospital admissions). While this would sound optimistic and perhaps encourage employers to push for more HMO enrollment, that is not always easy.

Companies usually offer employees a range of choices regarding health care plans, again, running the gamut from managed care plans to indemnity plans. Since managed care plans tend to attract the younger and healthier workers, indemnity plans tend to be disproportionate in the number of older and less healthy employees, as a result premiums for indemnity plans tend to be high. Again, this is a great deal like the situation of community versus experience rating raised in the last chapter--there is a form of cherry picking at work here.

Suddenly, a company finds that while it might be saving some health dollars through managed care plans (more saved through HMOs, less through PPOs) the already high and growing faster costs of indemnity premiums is offsetting savings from managed care plans. In fact, some companies have discovered that their overall medical costs increased after pushing managed care plans on their employees. As a result of the disillusionment associated with controlling health care spending, companies have attempted to shift more of the financial burden onto their employees. However,

that move has not been well received and, as a result, disagreement over health care plans is now the leading cause of labor strikes.(Aaron 33)

It is no wonder why companies such as the Chrysler Corporation, discussed in the first chapter as pushing for managed care programs as a means to control their medical costs and seeing savings by 1985, are now advocating some form of national health care plan. Chrysler is perhaps well ahead of a number of large companies in their thinking about health care reform, since many of these companies still prefer to see their attempts at controlling health care costs in terms of what they, as individual companies, can do for themselves, or what several large companies can do working together: the notion that health care reform will require a massive effort by companies of all sizes working together still seems to elude the thinking of many.

Regarding the Chrysler Corporation it found itself in the interesting quandary of supporting one interesting feature of the Clinton health act: the 7.9 percent cap on health benefits as a percentage of payroll expenditures that they would be required to meet in order to follow the guidelines of the plan. As noted in the first chapter, the Chrysler Corporation tried to use managed care as a means to control medical costs, but it seemed to not work. Chrysler is currently spending in the high teens as their percentage of health benefit costs to payroll, therefore the Clinton plan offered them a way to reduce their health costs. A number of large corporations (those with over 5,000 employees, therefore, the type of firm which would not have to join a strategic alliance as was

envisioned in the defunct health security act) are currently spending 10 percent and higher in their percentage of health care costs to payroll expenditures. Yet, despite this aspect of the administration's plan seen as helping to release corporation funds which could be used elsewhere, many corporation were still critical and leery of the health security act (the 7.9 percent cap only applied to firms joining a strategic alliance).(Winslow B5)

Many CEOs were of the opinion that the Clinton plan was "underfunded and overladen with government regulation."(Stout and Wartzman B5) To some extent, the percentage of payroll expenditures that a corporation spends on health care costs is somewhat related to the age of industry workers. In the case of the automobile and steel industries, workers tend to be older than in newer industries like high tech firms. As a result, older workers are more likely to incur more health care costs. John Welch, chairman and CEO of General Electric Company may have expressed an opinion of firms with a younger and different demographic employee base when he stated, "All the jawboning about health-care prices has clearly led to lower prices."(Stout and Wartzman B5) However, as pointed out in the last chapter, the overall workforce of the country is aging: it is only a matter of time before companies with younger work forces tend to see an employee aging process, which inevitably will have an impact on their health care spending.

Admittedly, some of the concerns about an underfunded Clinton health plan were not completely put to rest by the administration. For example, the purpose of the Clinton plan was to incorporate

all: provide universal coverage. Yet, several studies demonstrated that health claims costs increased noticeably where guaranteed coverage existed. The American Society of Actuaries found out that in a situation where guaranteed-issue policies existed, premiums were 38 percent higher.(Tanner) In order words, the Clinton plan called for, in essence, a community rating system within the structure of a strategic alliance, and community rating should help to bring premiums down, but there appeared to be some evidence that corporations voluntarily joining an alliance would not necessarily see their health care costs drop significantly. In fact, even if the alliances worked as planned, it would take up to eight years before companies saw a windfall from joining.

The way it was suppose to work, was that there would have been a phase-in process where large companies would have to pay a premium for four years. The idea was that a large corporation would have a profile of its workforce completed and if that profile showed they had older and sicker workers then they would pay more than the community rate for the alliance. After four years, there would be a gradual reduction in costs to the large employer. Therefore, while the health insurance cap and the idea of community rating sounded good to corporations like Chrysler, with their older workforce they might, in essence, be discriminated against by the alliance itself.

Large corporations perhaps felt that their incentives to join any alliance during the Clinton administration health care plan were outweighed by methods they had been developing over the last twenty years to address their health care costs. In 1974, Congress

passed the Employee Retirement Income Security Act (ERISA). ERISA contains a clause which allows companies to avoid state government regulation of their health insurance plans and further allows them to avoid paying state health premium taxes.

The development of self-insured company health plans is seen as the means to control health care costs. Self-insured means that a company assumes the risk of medical costs for the members of their plan. Basically, the idea is that a company takes funds that would go to pay health premiums and diverts them to a company health plan. Hopefully, after two or three years, a company has accumulated sufficient funds that they could cover any major medical problem. Since state premium taxes are not being paid, then those funds are also available for use in this company fund. Companies can see huge cash reserves, under this system, that can be diverted away from health care costs to other company expenditures or investments. Insurance companies are hired to administer these plans, but their role is a limited one.

Some self-insured companies take out "stop-loss" insurance which means that if there are significant medical cost that could seriously deplete the fund then the stop-loss insurance kicks in before reaching that point. The issue of stop-loss insurance has been raised in several federal district court cases around the country. The concern is whether a company that takes out stop-loss insurance is truly a self-insured company and, therefore entitled to the coverage ERISA provides from state taxes ands regulations. Court decisions have leaned in favor of companies

with stop-loss insurance which still allows these companies to exemptions from state government regulations.

In the 1970s when Goodyear Tire and Rubber Company and John Deere Company started self-insured programs, the issue of companies using ERISA as a means to escape state government regulations and the scope of the legal interpretations of ERISA were of minor importance. But as broader issues, such as the number of uninsured in the country and discussions about the best means to approach health care reform grew with the 1980s, increasingly ERISA with its escape clause for companies to avoid state regulations became a thorny issue.

In the past decade, self-insured companies have grown significantly: about half of all companies are now self-insured. Interestingly, while self-insured status appealed primarily to large companies, since they had the ability to more easily go that route, there has been a shift in the composition of companies that go self-insured. In 1988, only 8 percent of companies with less than 100 employees and 26 per dent of firms with 101-500 employees were self-insured, however, by 1995 those figures rose to 28 percent and 41 percent respectively.(O'Keefe 38)

If a company has a large employee base, say 5,000 employees, and it is assumed that its employees represent national health claims, it can more easily project its medical costs. In a Minnesota study, it was determined that 1 percent of enrollees in a health plan generated 30 percent of the insurance claims.(Wolman 131) In small firms, however, several major medical problems can significantly alter a firm's relationship to national averages and

affect the company's out-of-pocket expenditures. Small firms were reluctant to go self-insured since in a firm with under 100 employees, all that was needed was one or two major claims to completely drain a firm's health care fund and affect the medical care of everyone else. Small firms had to pray that for several years the employees and their dependents could stay healthy while the firm's health care fund had time to build up to a level where it could ride out several severe claims.

The idea of self-insured status with its ERISA protections can make sense to large companies with plants and locations in several states. By avoiding state government regulations, a large firm can develop a standardized health care package that crosses state lines; small firms, however, that exist in one state cannot point to the same rational for exemption under ERISA. The growth of small and mid-size companies developing self-insured health plans is leading increasingly to pressure on Congress and the courts to make changes in ERISA in order to allow states to provide some degree of regulation over companies with self-insured health plans.

Here is a point where large corporations may begin to see small firms adversely affecting their health plans. In November 1991, the United States Court of Appeals for the Fifth Circuit in New Orleans, made a ruling that immediately affected Louisiana, Texas, and Mississippi but which had broad ramifications for other parts of the country. A small Houston music store (so under 100 employees and located in one state) converted from a conventional health insurance plan to a self-insured program. In the process, the store significantly cut its benefits for AIDS-related claims after an

employee had already filed for AIDS treatment. Prior to the cut in benefits, the employee was entitled for up to $1 million in coverage, after the change he could receive no more than $5,000; the court ruled against the employee, citing ERISA. The Court of Appeals stated that a company that self-insures has "an absolute right to alter the terms of medical coverage available to plan beneficiaries." The attorney representing the employee stated, "it comes as no surprise that this issue arose first in the context of AIDS, but the principle at stake applies equally to leukemia, cancer, multiple sclerosis and other catastrophic illnesses. Self-insured is the route to discrimination for employees."(Pear: 1993 53)

In 1985, in the Supreme Court case of *Metropolitan Life Insurance Company v. Massachusetts*, the Court began to raise the issue that ERISA had, perhaps, been too broadly interpreted. In the *Travelers Insurance Company* case discussed in the last chapter, the Court seemed to move in the direction eluded to in the *Metropolitan Life* case. Large corporations are concerned that state government regulations could increase their health care costs. IBM spends $1 billion annually to cover its 500,000 employees and their dependents and has administrative costs of only 4-5 percent. The concern at IBM, and other large corporations, is that without ERISA, administrative costs would significantly increase. Here is a situation where large corporations need to look at the impact that the behavior of smaller firms can have on their health plans.

It is difficult to find a large corporation that defends ERISA protection for their health plans while, at the same time, criticizing

the change in the composition of firms that have gone self-insured. It may be difficult for large firms to have CEOs or other company spokesman stand up and defend self-insured status for a selective number of large companies in this country, but that is exactly what they need to do to prevent the mounting pressures they are aimed at reforming company freedom of action under ERISA.

The Republicans have championed the political position that the states need more independence from the federal government in order to reform both Medicaid and welfare, but Congress will probably have to reform ERISA to allow states to adequately reform health care. During the 1993 session of Congress, the House of Representatives passed a version of a bill designed to give the states more latitude to regulate employee health benefits, but the Senate failed to take up a similar bill so nothing happened. The House bill was sponsored by Representative William Ford (D., Mich.) who stated that he reacting to the way that the courts have broadly interpreted ERISA as exempting businesses from state health insurance regulations. (Congressional Quarterly Almanac 397) Admittedly, in 1995, after the Republicans took over control of both houses in Congress, ERISA proposed bills tended to favor business. For example, Representatives Harris Fawell (R., Ill.) and Bill Gooding (R., Pa.) introduced a bill which would have expanded ERISA coverage to prevent states from regulating small business health care plans; this bill failed to become law. (MacPherson)

The trend, however, is toward both Congress, under pressure from the states, and the courts to re-examine the scope of ERISA's

exemptions. In 1994, for example, state officials from both political parties lobbied Congress to revise ERISA allowing states to regulate health care plans previously covered by ERISA exemptions.(Pear: 1994). After the failure of Congress to pass the Clinton administration's health care plan, it was apparent to many that controversy over health care reform would shift to the states. George Halvorson, president of Health Partners, a Minneapolis-based HMO stated, "The battle will shift to the states...."(Freudenheim 22)

Usually, Hawaii is pointed to as the state that received exemption from ERISA so that it could proceed with major health care reforms, including employer-mandated health insurance. While national figures see approximately 15 percent of the country as uninsured, in Hawaii the figure is between 2-3 percent. In addition, insurance premiums are 50 percent lower than elsewhere in the country.(Haloweiki)

In the case of Hawaii, the state's Prepaid Health Care Act took effect on January 1, 1975, at a time when medical costs were not yet a major national concern. As medical costs began to increase elsewhere in the country, companies pushed for experience rating (as discussed in the last chapter) or they began to self-insure. As a result of this segmenting of the health care market a situation was created where smaller companies (with medically uninsurables) saw their premiums go up significantly, so they began to drop their health care plans--the rise of the working uninsured. It has been noted that between 1988 and 1993, Americans living two to four times higher than the poverty line ($14,764 for a family of four in

1993) are the ones losing insurance coverage. For example, the percentage of families with incomes below the poverty level and no health insurance fell between 1988 and 1993, but in the following three categories, families with incomes at twice the poverty line, between two and four times the poverty line, and those at more than four times the poverty line, all saw an increase in uninsured status.(Bradsher)

In the case of Hawaii, the health insurance market could not be segmented since all companies had to provide certain basics in their health care plans. By mandating coverage, the Hawaiian Prepaid Health Care Act, essentially, stabilized premiums.

In looking at the changing composition of self-insured firms, both political and legal pressures will mount to alter ERISA. It is anyone's guess how this will affect self-insured firms, but large corporations need to realize that the future of their health care plans is interwoven with the actions of a music store in Houston and the reaction that will mount to court decisions that support the store. One study that examined ERISA and its role in preventing states from implementing health care reform concluded:

> *If it is impossible to fold self-insured employees into [a state-led health care] system because of ERISA, as it is everywhere except in Hawaii, then states cannot build comprehensive systems. To oversimplify, but not much, ERISA preemption means that the people who have the lowest health risks and the highest abilities to pay will be outside of the state [health care] systems.*(Mashaw 16)

The growing issue of self-insured plans with discriminating side-effects becoming a rationale for states to push for restrictions on ERISA is really an outgrowth of an issue that has been underway since, at least, the early years of this century. Health insurance has always chased after the young, the healthy, those least in need of health care coverage. One study that looked at life insurance in the last century concluded:

> *For most of the nineteenth century life insurance was sold only to people who could pass a medical examination. People who already had a personal or family history of disease, or for that matter worked in occupations deemed hazardous or unsavory, were refused insurance and labeled by the [life] insurance companies as 'uninsurable risks.'* (Stone 295)

In the case of offering health insurance, certain individuals were deemed as risks that companies should not insure. For example, a 1930 pocket guide to agents issued by the Northwest Union Life Insurance Company defined some of the uninsurable risks as "Negroes, Chinese, Japanese, Mexicans and more than one-fourth blood Indians." A 1931 guide stated that insurance for menopausal women was not a good idea because, "[they have] disturbed physical functions of many kinds, nervousness being particularly common."(Stone 296)

Between 1934 and 1945, thirty-five states passed laws creating Blue Cross plans as hospital corporations. These hospitals were exempt from many state laws including the payment of premium taxes as a tradeoff for understanding that they would provide health insurance and service for all regardless of whether patients

could pay. So the legal philosophy behind states willing to exempt certain health organizations from state regulations was a trade-off that benefited many. However, as experience-rated insurance companies moved to challenge the power of the Blues by offering lower premium rates to companies who fit the profile of having healthy employee pools, the legal philosophy that exempted certain health organizations from state regulatory guidelines began to be challenged.

The insurance industry has claimed that 10-15 percent of people covered by commercial health insurance are subject to medical underwriting (described as the search for the most desirable insurees), however, the actual percentage may be a great deal higher.(Stone 306) While more companies of many sizes are willing to self-insure to escape state regulations, whatever benefits this method of health care is providing to large corporations may be easily undermined by very visible and apparent discriminatory practices.

Large corporations may not clearly understand the stake that they have in health care reform. Business had never been reluctant to speak out about tax reform, government regulatory practices or environmental protection laws, but health care costs is another issue. As one author looking at the role of business in the health care reform debate stated, "however annoying [health care is to business it] took a back seat politically to arenas that spoke more directly to the heart of business profits and autonomy."(Brown 345) This may explain why few businesses of different sizes seem

to work together to address health care costs similar to the Rochester model discussed in the previous chapter.

Large corporations have assumed that they have found some means to address health care costs, such as the managed care arrangements and self-insured programs discussed in this chapter. But, both of these methods of addressing health care costs are approaches that encourage individual businesses to look at health care from a company level rather than from a broader perspective. Neither of these approaches to health care reform encourages large corporations to work collectively with companies of different sizes. Since the predominant means toward addressing health care reform from a broad perspective usually means that either the state or federal government will be involved, then business is reluctant to look at an issue that will affect both their profits and management-employee relations from that larger perspective.

In addition, the Rochester model may not be applicable since it is not a recent development but has its roots in the 1920s well before recent developments in health care started to rise with the mid-to-late 1970s. The Rochester model pre-dates managed care plans and self-insured programs. The irony of both managed care and self-insured methods to controlling health care costs for large companies is that they may hold out some hope but they also serve to prevent these companies from looking at other methods which may lead to more lasting methods of controlling health care costs. Both managed care and self-insured status are recent developments and whether they can really provide adequate means to controlling health care dollars is still being questioned. For businesses, both

large and small, to seriously consider working together to control their health care costs it will necessary for the percentage of the working population of this country not covered by health insurance to continue increasing and for more states, not just New York, to place high taxes on patients entering hospitals covered by self-insured plans to pay for the state's cost of caring for the uninsured and for courts to hand down rulings restricting ERISA. In other words, business may have to go through a period of realizing that their inability or unwillingness to work together has been harmful to businesses of all sizes.

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Chapter V
Conclusion: Is it Possible for Businesses of Different Sizes to Cooperate on Health Care Reform?

In the mid-1970s, facing intense competition from the Japanese, the American semi-conductor industry came together to form an association with the purpose of lobbying both Congress and the Carter administration to provide protection and assistance for their industry. Companies that had been (and still are) in competition with each other, realized the need to work together.

During the Reagan administration years, the success of the semi-conductor industry managing to work together saw its efforts pay off. Company CEOs directly lobbied members of Congress, a development that had an impact on Senators and Representative use to dealing with paid lobbyists. The industry received certain exemptions from anti-trust laws that allowed them to form a joint research and development consortium that allowed companies to pool their resources as a way of sharing the huge costs of preparing for the next generation of computers. In addition, the industry managed to get financial assistance from the Department of Defense which came to realize that it was in the interest of national security to help an industry with a direct relationship to the functioning of sophisticated weapons systems. Furthermore, the Reagan administration put pressure on the Japanese to end the practice of "dumping" where they sold computer chips at well below market cost as a way to break into and then expand their position in the American market.(Yoffie)

By the late 1980s, the semi-conductor industry's efforts had begun to pay off: the industry was, once again, seen as competitive with the Japanese. The moral of this story is not just that an industry received help from the federal government and saw positive results from that help (certainly a challenge to the conventional conservative political view that government can only hinder not help business) , but that businesses of different sizes learned to work together to address a common problem.

In the early years of attempting to form the semi-conductor association and reach some common consensus on what was wanted from the federal government, companies of different sizes had to learn how to work together. In particular large corporations had to learn they had a stake in working with their smaller domestic competitors in order to develop a common approach toward addressing Japanese competition. In the case of health care costs for businesses of different sizes, the lesson of the semi-conductor industry has not yet been learned--or frequently applied.

During the period when Congress was considering the Clinton administration's health care reform plan, the associate editor of the *St. Petersburg Times* (Florida) found it odd that the Florida Congressional delegation was so hostile to universal health care since the state has 24.5 per cent of the state's population under 65 uninsured. There are only four other states that have a higher percentage of uninsured: Oklahoma, Texas, Louisiana, and Nevada. In other words, the Clinton health care plan was seen, by this associate editor, as beneficial to the state of Florida, but Florida's Congressional delegation never saw it that way.

Understandably, Republican representatives would have a difficult time showing support for a Democratic President's plan, however, one would assume that the interests of their state should outweigh the interests to their political party. (Dyckman)

Regarding the Florida Congressional delegation and its opposition to the Clinton health care plan, some of this opposition was reflective of national opposition that raised the question "What crisis?" (Stelzer) For example, while national figures of 15 percent are often cited as indicating the percentage of the population that is uninsured, how this figure is interpreted varies. One study pointed out that about half of the uninsured have that status end within six months. So, the idea is that the uninsured are seen as a transient group that is shifting in and out of uninsured status. This concluding project certainly recognizes the need to be aware of different interpretations of the percentage of the population that is uninsured, however, the basic underlying issue that has been raised (that small companies increasingly are not providing health insurance to their employees and that this will affect the ability of big business to provide health insurance to their employees leading to the need for businesses of different sizes to work together on health care reform) is still relevant and growing in importance.

In the case of Florida's Congressional delegation, apparently health care reform was not seen in crisis proportion terms. In the case of the semi-conductor industry, on the other hand, Japanese competition was seen in terms of being a major threat to their industry and that provided the climate that forced companies of

different sizes to work together to resolve their differences in order to confront a mutual problem.

When does an issue that seems to be a serious problem to some become a severe problem to many? The Great Depression in the 1930s, with its devastation to the American economy and its unemployment rates that went as high as 28 per cent and hovered above 18 per cent for almost a decade, acted as a "big bang" that forced politicians of different political ideological leanings to learn to work together. Health care reform and the issue of the working uninsured are not yet seen in the context of being severe problems to many.

Robert Axelrod in *The Evolution of Cooperation* (discussed in chapter two), addresses the need to "enlarge the future" as the means to bringing about cooperation between two "players." Axelrod's book is based on game theories so discussion of cooperation centers around two players and how they come to cooperate with each other. In the case of the need to "enlarge the future," Axelrod believes that if the future is less important than the present, then the desire to cooperate will not be easily found. In order to get large companies to work with small firms, perhaps along the lines of the Rochester model (discussed in chapter three), it is necessary to make the future loom large in the present. For example, in the *Travelers Insurance Company* case (discussed in chapter four), self-insured companies are now being taxed in New York state to help finance the state's expenses of covering the working uninsured. Will self-insured companies begin to realize that they are, essentially, helping to pay for the health insurance of

employees at companies that refuse or are unable to provide health care benefits? The answer to this question may depend on how many states follow the lead of New York and begin taxing self-insured plans in their states.

Axelrod believes that frequent interaction is needed between "players" in order for cooperation to develop, As one reads this concluding project, it is difficult to find situations where the author discusses businesses of different sizes interacting on the issue of health care costs. In chapter three, the Rochester model is discussed and brief mention is made of a health care plan in Colorado that has recently begun to bring together companies of different sizes. In the case of the Rochester model it was noted that this was unique to the Rochester, New York area in that cooperation among companies of different sizes extended back to the 1920s. In the case of recent developments in Colorado, it was pointed out that the structure of the state's businesses is unique and that has provided the necessary condition for businesses of different sizes to begin to work together on health care cost controls. The point that one needs to be bear in mind is that cooperation among companies of different sizes on health care costs is rare; both Rochester and Colorado are examples with unusual circumstances.

If the foundation for cooperation between businesses of different sizes is lacking, meaning little in the way of frequent interaction, then it is debatable whether the immediate future looks bright for large and small businesses learning to work together to effectively address the issue of health care costs for their

employees and dependents. As the working uninsured grow in numbers, as Congress and the courts being to revise ERISA interpretations, and as managed care plans begin to look less like long-term solutions to controlling health care costs that many companies would like them to be, then the stage may be set for companies of different sizes to realize the need to work together.

One bright note to end on is that health care as a crisis is only a recent development that began to become noticed with the 1980s. During that decade, medical expenses increased by 117 percent; inflation accounted for 50 percent of that increase, 12 percent is related to the population growing and getting older, 27 percent of the increase was caused by medical technology and drugs not available in 1980, and 28 percent of the increase is related to health care as an industry. (Gordon) That final category is where attention focused on controlling health care costs is concentrated. The 1990s may be seen as the decade that has begun to respond to health care as a crisis, which means that effective means aimed at controlling health care costs is only beginning to take root.

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